

2 1 3
FOR STATE
HEALTH DEPT.
M

Item 1208 Form 206
1-29-62 a.m.
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00554 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
111551

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-instruction form. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY DORCHESTER		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 6 mo. 14 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL			
3. NAME OF DECEASED (Type or print) ROBERT E. ALDRICH SR.		First	Middle
4. DATE OF DEATH JANUARY 21 1962		Last	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/81
		WIDOWED <input type="checkbox"/>	9. AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANKER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM T. ALDRICH		14. MOTHER'S MAIDEN NAME CARRIE TERRELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 183-03-6736	
17. INFORMANT RECORDS E.S.S. HOSP.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) TERMINAL PNEUMONIA FRACTURE NECK R. FEMUR	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell on floor	
20c. TIME OF INJURY Month, Day, Year Hour 4:15 p.m. 12-10-1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOSPITAL	
20f. (City or town) CAMBRIDGE		(County) MD	
(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mac Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN MAC JR.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 15, 1962 at Mount Saint Paul Hill		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF JAN 15, 1962		Address (Street, city, town, or county) Phila.	
22c. NAME OF CEMETERY OR CREMATORIAL Mount Saint Paul Hill		(State) Pa.	
23. FUNERAL DIRECTOR Edgar L. Lane Church Hill Rd.		24a. REC'D BY REGISTRAR JAN 24 '62	
ADDRESS Church Hill Rd.		24b. REGISTRAR'S SIGNATURE James S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00553

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Woolford		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woolford		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Alexander	Middle 	Last Bailey	4. DATE OF DEATH Month January	Day 20	Year , 1962
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years (last birthday) yrs.) 54	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS. Days 	12. Hours 	13. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Dor-Co-Md.	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME John W. Bailey	14. MOTHER'S MAIDEN NAME Martina Bryan
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO. WW II 217-10-8255	17. INFORMANT Mrs Martina Bailey-Woolford, Md.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 1wk
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)		Bronchopneumonia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)
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21. I certify that I attended the deceased from January 13, 1962 to January 20, 1962 that I last saw the deceased alive on January 20, 1962 , and that death occurred at 11 AM , from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>	ADDRESS (Street, city or town, state) M.D. 227 Pine St., Cambridge, Md. 1-20-62			
DATE SIGNED 				

22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 1/21/62	22c. NAME OF CEMETERY OR CREMATORIAL Madison Cemetery	22d. LOCATION (City, town, or county) Madison-Dor-Md.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert M. St. Clair</i>	ADDRESS High St., Cambridge, Md.	24a. REC'D BY REGISTRAR JAN 30 '62	24b. REGISTRAR'S SIGNATURE <i>Robert S. Fassett</i>
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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00556

CERTIFICATE OF DEATH

00554

1. PLACE OF DEATH

COUNTY
Dorchester

MARYLAND

b. CITY OR TOWN (if outside corporate limits,
write RURAL and give nearest town)

rural Cambridge, Md

c. LENGTH OF STAY IN 15

4 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Eastern Shore State Hospital

3. NAME OF
DECEASED
(Type or print)

First John Victor

Middle

Last Bell

4. DATE
OF
DEATH
January

Day 28 1962

5. SEX

male

6. COLOR OR RACE
white7. MARRIED NEVER MARRIED
WIDOWED DIVORCED 8. DATE OF BIRTH
12/ 20/ 779. AGE (In years
last birthday)
84 yrs.IF UNDER 1 YEAR
Months DaysIF UNDER 24 HRS.
Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

waterman

10b. KIND OF BUSINESS OR INDUSTRY

Fishing

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Bell

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Medical Records, ESSH Cambridge, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

arteriosclerotic heart disease, decompensated

INTERVAL BETWEEN
ONSET AND DEATH
linkConditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.DUE TO
(b)DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m. 20d. INJURY OCCURRED
at work Not While
p.m. 19 of work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1/25/1962 to 1/28/1962, that (I) (we) last
saw the deceased alive on 1/28/1962, and that death occurred at 3:15 P.M. from the causes and on the date stated above.

22e. SIGNATURE

Houston Foster

M.D.

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS. 22b. DATE
SIGNED
1/28/6222c. PHYSICIAN'S
NAME (Type)

Houston Foster, MD

E.S.S.H. Cambridge, Md

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF
Jan. 31, 1962 Family Cemetery

23d. LOCATION (City, town or county)

(State)

Castle Haven,

Maryland.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS CAMB

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

RECOMPTON FUNERAL SER. MD

DATE FEB 1 '62

Arthur E. Thomas

TO HOSPITAL OR
death. Patient may be
TO FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, fold, and in any event, within 72 hours after death,
be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after

VR A15 (4)
15M 7/61

2205

2000-2001

2000-2001

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FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00555

1. PLACE OF DEATH

a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b
24 yr. 3 mo.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Eastern Shore State Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Edith

Catherine

Brown

4. SEX

F

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

3-8-79

4. DATE
OF
DEATH

January 9

19 62

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unknown

10b. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Madison Brown

14. MOTHER'S MAIDEN NAME

Priscilla Emory

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

NO

16. SOCIAL SECURITY NO.

-

17. INFORMANT

-

Address

RECORDS - Eastern Shore State Hospital

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

Myocardial Failure

INTERVAL BETWEEN
ONSET AND DEATH

2 days

260 X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

Fracture neck humerus. Diabetes Mellitus

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Slipped and fell to floor

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
12.35 PM. 1/10/61 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
Cambridge

(County) Dor. Md. (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

John Mace Jr.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

1/9/62

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

Chester Field

22d. LOCATION (City, town, or county)

Centreville

(State)

23. FUNERAL DIRECTOR

ADDRESS

24e. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

VS. A.I.S.M.E.
5M 9/60

Edgar L. Lane Chuk Hill Me.

DATE JAN 15 '62

Arthur E. Kress

Journal of Early American Studies

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 3 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00558

CERTIFICATE OF DEATH

00556

1. PLACE OF DEATH

a. COUNTY

Dorchester Co.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge, Md.

c. LENGTH OF STAY IN lb

50 Years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Cambridge Md. Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle

Lucy Foxwell

Cannon

Last Month
Jan.

4. DATE
OF
DEATH

6 Day
Jan. 7, 1962

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Oct. 28, 1872

9. AGE (In years
last birthday)

89

10. IF UNDER 1 YEAR
Months Days

11. IF UNDER 24 HRS.
Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Meekins Neck, Dorchester, Co.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert H. Foxwell

Margaret Ann Foxwell

Address

14. SOCIAL SECURITY NO.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Phillip Cannon

108 Cemetery Ave. Camb.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

525X

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Hypocoardial Failure

Fibrosis Lungs (severe)

Sciatica

INTERVAL BETWEEN
ONSET AND DEATH

5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Collapse Dorsal Vertebrae

19. WAS AUTOPSY
PERFORMED?

YES

NO

20a. ACCIDENT/WAS UNDERLYING

OP. CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.
p.m.

19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1962, to Jan. 7, 1962, (I) (we) last saw the deceased alive on Jan. 7, 1962, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Dr. W. H. Hanks

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type)

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Jan. 8, 1962

23c. NAME OF CEMETERY OR CEMETORY

Cambridge Cemetery

23d. LOCATION (City, town or county)

(State)

Cambridge,

Md.

24 FUNERAL DIRECTOR'S SIGNATURE

LeCompte Funeral Service

ADDRESS

25a. REC'D BY REGISTRAR

JAN 12 '62

DATE

25b. REGISTRAR'S SIGNATURE

Arthur L. Kraus

M

1. *Calocedrus* (Lindley)

2. *Calocedrus* (Lindley)

3. *Calocedrus* (Lindley)

4. *Calocedrus* (Lindley)

5. *Calocedrus* (Lindley)

6. *Calocedrus* (Lindley)

The law requires that the death certificate be executed within 24 hours after death. This may be done by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00559

00557

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Dorchester Co. MARYLAND		b. STATE Md.	
b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Cambridge, Md.		2 Years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
Glasgow Nursing Home		Cambridge, Md.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Benjamin		Jan. 17, 1962	
First Middle		Last Month Day Year	
5. SEX		6. COLOR OR RACE	
Male White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
DIVORCED <input type="checkbox"/>		Oct. 26, 1887	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None		None	
13. FATHER'S NAME		11. BIRTHPLACE (County & State, or foreign country)	
Benjamin Carmine		Lewis, Del.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank, dates of service)		16. SOCIAL SECURITY NO.	
No		Unknown	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
Mrs. James Thompson 109 Oakley St. Cambridge, Md.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure, congestive</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Arterio-sclerotic CVD & coronary insufficiency - 10 yrs</i> DUE TO (c) <i>Arterio-sclerotic Jan</i> years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from..... 1951, to..... Jan 17, 1962, that (I) (we) last saw the deceased alive on..... Jan 17, 1962, and that death occurred at 3 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 1/19/62	
22e. SIGNATURE <i>James H. Thompson</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22f. PHYSICIAN'S NAME (Type) <i>J. H. Thompson</i>		23a. ADDRESS <i>Cambridge, Md.</i>	
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORIAL Christ Churchyard	
23d. DATE THEREOF Jan. 19, 1962		23e. LOCATION (City, town or county) Cambridge, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		25a. REC'D BY REGISTRAR JAN 29 '62 25b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	
15M 7/61		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00560

CERTIFICATE OF DEATH

Reg. Dist. No. 001558

TO HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 4 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Alice Middle Donovan		d. STREET ADDRESS Buckingham Arms Apts.	
4. DATE OF DEATH January 22, 1962		Month Day Year 1962	Day Year 1962
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 2, 1887
9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Hoboken, N.J.	
13. FATHER'S NAME Augustine Donovan		14. MOTHER'S MAIDEN NAME Anna Laura Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Maj. Henry R. Cook, Claiborne, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arterio-cardio-vascular renal disease DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 year +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on		12-30-61, 19	1-22-62, 19
1-22-62, 19		7:30 P.M.	that I last saw the deceased from the causes and on the date stated above.
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state) 15 Locust Street		DATE SIGNED 1-22-62
PHYSICIAN'S NAME (Type)	Eldridge H. Wolff, M.D. Cambridge, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 25, 1962	22c. NAME OF CEMETERY OR CREMATORIUM St. Dennis Cemetery	22d. LOCATION (City, town, or county) Havertown, Pa. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Benjamin R. Thomas		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE JAN 29 '62
			24b. REGISTRAR'S SIGNATURE Arthur J. Frazee



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00561

CERTIFICATE OF DEATH

Reg. Dist. No.

011559

TO HOSPITAL OR ATTENDANT: **PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death by the physician or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

M

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb five yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 156 Washington St			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Jannie		First	Middle	Lost	4. DATE OF DEATH January 12 1962	Month	Day	Year	
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 13, 1895	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Dor-Co-Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Keene		14. MOTHER'S MAIDEN NAME Mary R. Lee							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-01-7961		17. INFORMANT Miss Virginia Cooper-Cambridge, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage								INTERVAL BETWEEN ONSET AND DEATH 2wks	
442X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hypertensive Cardiovascular Renal Disease									
DUE TO (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) Cambridge (State) Md.			
21. I certify that I attended the deceased from January 2, 1962 to January 12, 1962 that I last saw the deceased alive on January 12, 1962 and that death occurred at 227 Pine St., Cambridge, Md. on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St., Cambridge, Md. DATE SIGNED 1-13-62									
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		M.D. 227 Pine St., Cambridge, Md. 1-13-62							
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/62		22c. NAME OF CEMETERY OR CREMATORIAL Madison Cemetery		22d. LOCATION (City, town, or county) Madison-Dor-Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert H. Sofield</i>		ADDRESS High St-Cambridge, Md.		24a. REC'D BY REGISTRAR JAN 3 0 62		24b. REGISTRAR'S SIGNATURE <i>Robert H. Sofield</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Fill in page 3 and in any event, within 72 hours after death, be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

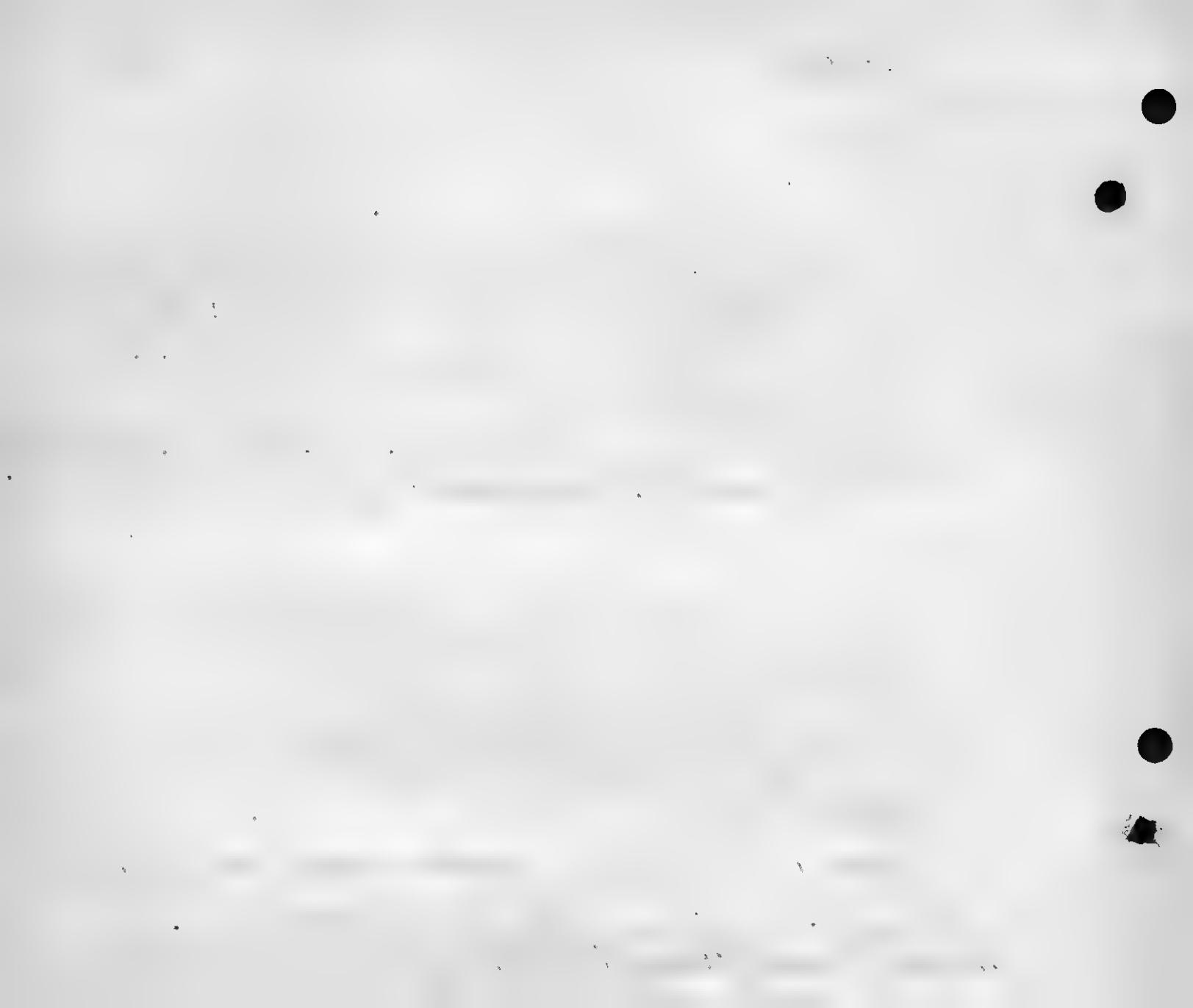
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00562

CERTIFICATE OF DEATH

00568

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
a. COUNTY <i>Dorchester</i>		a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		b. COUNTY <i>Dorchester</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Eastern Shore State Hosp. & L</i>		d. STREET ADDRESS <i>Locust St.</i>	
3. NAME OF DECEASED (Type or print) <i>First: ETHEL Middle: HENRY</i>		4. DATE OF DEATH <i>Last: FELL Month: JANUARY Day: 19 Year: 1962</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/25/1877</i>	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (County & State, or foreign country) Dorchester Maryland</i>	
13. FATHER'S NAME <i>Hampton HENRY</i>		14. MOTHER'S NAME <i>Le Compte</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Address: Miss Helen W. Fell, Aurora St., Cambridge</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio vascular degeneration</i>		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
DUE TO <i>+20.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 29 1955</i> to <i>Jan 19 1962</i> that (I) (we) last saw the deceased alive on <i>Jan 29 1962</i> and that death occurred at <i>7390 M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>John F. Schneider M.D.</i>		22b. DATE SIGNED <i>Jan 1962</i>	
22c. PHYSICIAN'S NAME (Type) <i>John F. Schneider</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan 21, 1962</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Christ Church Cemetery Cambridge, Md.</i>		23d. LOCATION (City, town or county) (State) <i>Cambridge, Md.</i>	
24. FUNERAL DIRECTOR (Type) <i>Thomas Funeral Home Locust St.</i>		25a. REC'D BY REGISTRAR <i>DAJAN 24 '62</i>	
		25b. REGISTRAR'S SIGNATURE <i>John F. Schneider</i>	



TO HOSPITAL OR ATTENDANT: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film 0306 0306 2/5/62 1W 00563 00563

1. PLACE OF DEATH a. COUNTY DORCHESTER		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE, MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE R.F.D. 3 BOX 31	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS RFD# 3 Centreville, Md. 1/2 1	
3. NAME OF DECEASED (Type or print) CARTER EDMONDS		4. DATE OF DEATH Month JANUARY Day 27 Year 1962	
5. SEX M	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-3-85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Seldon Graves		14. MOTHER'S MAIDEN NAME Lena Edmonds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Unknown
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO 42 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHEROSCLEROTIC C.V.D. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 HOUR ? YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
ASCENDING URINARY TRACT INFECTION; PNEUMONIIT			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-13 1962 to 1-27 1962 that (I) first last saw the deceased alive on 1-26 1962 and that death occurred at 12:45 from the causes and on the date stated above.			
22a. SIGNATURE Geo M Dunn		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 1/27/62
22c. PHYSICIAN'S NAME (Type) GEO. M. DUNN, M.D.		22d. ADDRESS ESTERN SHORE STATE HOSPITAL CAMBRIDGE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) 13		23b. DATE THEREOF 1/29/62	
23c. NAME OF CEMETERY OR CREMATORIAL GARTH CHAPE/		23d. LOCAT ON 100 (town, or county) ALBEMARLE (State) VA	
24. FUNERAL DIRECTOR'S SIGNATURE HAYES LE COMPTON		ADDRESS CAMB. MD.	
25a. REC'D. BY REGISTRAR FEB 1 1962		25b. REGISTRAR'S SIGNATURE Calvin S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

M

00564

04562

1. PLACE OF DEATH

a. COUNTY

1. M
Yorchester.

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge.

c. LENGTH OF STAY IN lb

From 9/30/58

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Eastern Shore State Hospital

3. NAME OF
DECEASED
(Type or print)First
ClarenceMiddle
Moore

5. SEX

M.

6. COLOR OR RACE

W.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Waterman.

13. FATHER'S NAME

JOHN Hadaway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

415-14-4094.

Eastern Shore State Hospital.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)450.6
DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.(b)
DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.(c)
DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

Bronchopneumonia

Generalized arteriosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

3 days

several yrs.

MEDICAL CERTIFICATION

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (e) 19. WAS AUTOPSY
PERFORMED?Cerebralclerosis. associated with Senile Brain Disease. Psych. YES NO

20a. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
19
p.m. While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 9/30/1958, 19, to 1/21, 1962, that (I) (we) last saw the deceased alive on Jan. 20, 1962, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Simon Virkutis M.D. 22b. DATE
SIGNED
1/21/1962

22c. PHYSICIAN'S NAME (Type) Simon Virkutis

22d. ADDRESS E.S.S. Hospital. January 21, 1962.

23a. BURIAL CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION (City, town or county) (State)

Burial 1-24-62 Rehoboth Cemetery Rehoboth, Md

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

J. Hampton Garrison ADDRESS DATE JAN 23 '62 C. S. Tamm

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be done by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. To FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. To be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AHS 14
15M 7 67



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

011564

M

00565

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 1 yr. 3 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillsboro		d. STREET ADDRESS Hillsboro		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS Hillsboro		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ethel		First S.	Middle	Last Holt	4. DATE OF DEATH Jan 17 1962	Month	Day	Year
5. SEX F		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 2-24-83	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Holt, James		14. MOTHER'S MAIDEN NAME Beaver, Grace						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 213-12-5483		17. INFORMANT Hospital records		Address Cambridge Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a). 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b). DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge		(County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 17 1960, to Jan 17 1962, that (I) (he) last saw the deceased alive on Jan 16 1962, and that death occurred at 12:30 P.M. from the causes and on the date stated above.								
22a. SIGNATURE Thomas J. Dredge								
22c. PHYSICIAN'S NAME (Type) Thomas J. Dredge, M.D.		M.D.		ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 1/17/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 20/62		23b. DATE THEREOF Jan 20/62		23c. NAME OF CEMETERY OR CREMATORIAL Hillsboro Md		23d. LOCATION (City, town, or county) Hillsboro Md		
24. FUNERAL DIRECTOR'S SIGNATURE Lyle Moon & Son Denton		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 23 '62		25b. REGISTRAR'S SIGNATURE C. Lewis, R. Lewis		

TO HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
may be re-used by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00566

CERTIFICATE OF DEATH

00565

1. PLACE OF DEATH

a. COUNTY

Dorchester MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge 3 wks

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Cambridge Maryland

2. NAME OF DECEASED
(Type or print)

First Charles Middle Augustus Last Howard

3. SEX

4. COLOR OR RACE

5. MARRIED NEVER MARRIED

6. WIDOWED DIVORCED

7. DATE OF BIRTH

8. AGE (in years
at birthday)

9. IF UNDER 1 YEAR
yrs.

10. IF UNDER 24 HRS.
Months Deyrs Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (County & State or foregn country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes, give number of service)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4 DUE TO

Conditions, if any, which

gave rise to immediate cause

(b)

(c)

gave rise to underlying cause

(d)

slowing the underlying

cause (e)

cease test.

(f)

slowing the underlying

cause (g)

cease test.

(h)

slowing the underlying

cause (i)

cease test.

(j)

slowing the underlying

cause (k)

cease test.

(l)

slowing the underlying

cause (m)

cease test.

(n)

slowing the underlying

cause (o)

cease test.

(p)

slowing the underlying

cause (q)

cease test.

(r)

slowing the underlying

cause (s)

cease test.

(t)

slowing the underlying

cause (u)

cease test.

(v)

slowing the underlying

cause (w)

cease test.

(x)

slowing the underlying

cause (y)

cease test.

(z)

slowing the underlying

cause (aa)

cease test.

(bb)

slowing the underlying

cause (cc)

cease test.

(dd)

slowing the underlying

cause (ee)

cease test.

(ff)

slowing the underlying

cause (gg)

cease test.

(hh)

slowing the underlying

cause (ii)

cease test.

(jj)

slowing the underlying

cause (kk)

cease test.

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cause (mm)

cease test.

(nn)

slowing the underlying

cause (oo)

cease test.

(pp)

slowing the underlying

cause (qq)

cease test.

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cause (ss)

cease test.

(tt)

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cause (uu)

cease test.

(vv)

slowing the underlying

cause (ww)

cease test.

(xx)

slowing the underlying

cause (yy)

cease test.

(zz)

slowing the underlying

cause (aa)

cease test.

(bb)

slowing the underlying

cause (cc)

cease test.

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cause (ee)

cease test.

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cause (gg)

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cause (ii)

cease test.

(jj)

slowing the underlying

cause (kk)

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cease test.

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cause (oo)

cease test.

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cause (qq)

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00567

CERTIFICATE OF DEATH

00566

1. PLACE OF DEATH

a. COUNTY

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 10 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

a. IS RESIDENCE
ON A FARM?YES NO

3. NAME OF DECEASED (Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. FATHER'S NAME

13. MOTHER'S NAME

14. WAS DECEASED EVER IN U.S. ARMED FORCES? 15. SOCIAL SECURITY NO. 16. INFORMANT

(Yes, no, or unknown) (If yes give rank or dates of service)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1561 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour a.m.

19

While at work Not While at work

21. I certify that (I) (this hospital) attended the deceased from Dec. 7 1959 to Jan 5 1962, that (I) (we) last saw the deceased alive on Jan 5 1962, and that death occurred at 7 AM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

22d. STANDING
M.D. M.S. STAFF PHYS. 22b. DATE SIGNED
1-8-6223a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR
JAN 11 '62

DATE

25b. REGISTRAR'S SIGNATURE
Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Please be referred to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE
HEALTH DEPT.

4 Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00568 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Dorchester

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural, East New Market

c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

R.F.D. Cabin Creek Rd.

3. NAME OF
DECEASED
(Type or print)

First
Amos

Middle
Hubert

Last
Jackson

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED NEVER MARRIED

WIDOWER

8. DATE OF BIRTH

DIVORCED

Oct. 11, 1892

9. AGE (in years
last birthday)

69 yrs.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Day Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Farm

11. BIRTHPLACE (State or foreign country)

Maryland

13. FATHER'S NAME

Charles W. Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

217-03-8014 Alma Conaway

Address

East New Market, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

420 Coronary occlusion

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

ACTUAL

EXAMINER'S
NAME (Type)

John Mace M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 1/13/62

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL
East New Market Cemetery

22d. LOCATION (City, town, or country)
Dorchester, Md.

23. FUNERAL DIRECTOR
Ruth Willoughby

ADDRESS
East New Market, Md.

24e. REC'D BY REGISTRAR JAN 18 '62

24f. REGISTRAR'S SIGNATURE
Walter S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 001568

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cambridge-Rural		d. STREET ADDRESS RFD #3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Mannie	Middle Jenkins	4. DATE OF DEATH Lost January	Month 18,	Doy 19	Year 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1879		9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dor-Co-Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John W. Jenkins		14. MOTHER'S MAIDEN NAME Eliza Tubman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO 214-07-7713		17. INFORMANT Mrs. Carrie Jenkins-Cambridge, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D. 227 Pine St., Cambridge, Md-1-19-62	(County)	(State)
21. I certify that I attended the deceased from January 4 1962, to January 18 1962, that I last saw the deceased alive on January 18, 1962, and that death occurred at 8 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 22. DATE SIGNED ACTUAL SIGNATURE J. Edwin Fassett, M.D.								
23. PHYSICIAN'S NAME (Type)		24. BURIAL, CREMATION, REMOVAL (Specify) Burial		25. DATE THEREOF 1/21/62	26. NAME OF CEMETERY OR CEMETORY Bethel Cemetery	27. LOCATION (City, town, or county) Cambridge, Md.	(State)	
28. FUNERAL DIRECTOR'S SIGNATURE Herbert McElroy		29. ADDRESS High St., Cambridge, Md.		30. REC'D. BY REGISTRAR JAN 30 '62	31. DATE	32. REGISTRAR'S SIGNATURE L. S. Turner		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00569

00570

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X East New Market - Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital				d. STREET ADDRESS Railroad Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First Corinthian	Middle Martin	Last Jolley	4. DATE OF DEATH	Month January	Day 7	Year 1962
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 26, 1961	9. AGE (In years last birthday) yrs. Months 11	10. IF UNDER 1 YEAR Days	11. IF UNDER 24 HRS Hours	12. IF UNDER 24 HRS Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Cambridge, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Thomas Henry Jolley	14. MOTHER'S MAIDEN NAME Essie Batson
--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Essie B. Jolley, East New Market, Md.	Address
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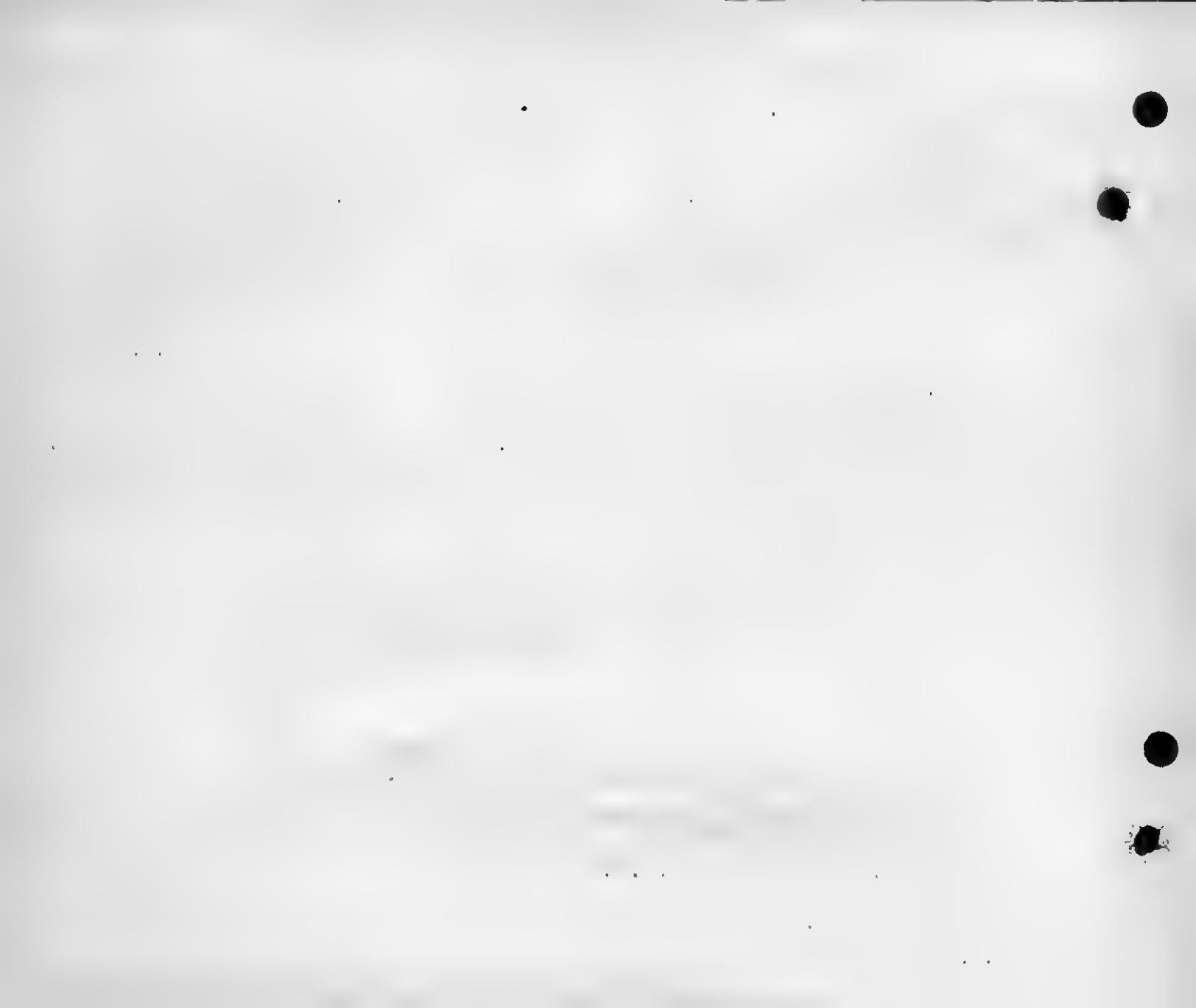
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH 13 days
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7/16 Premature DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 26, 61 to January 7 1962 that (I) (we) last saw the deceased alive on January 7 1962, and that death occurred 12:45 AM the causes and on the date stated above	
22a. SIGNATURE <i>J. Edwin Fassett</i>	22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS 227 Pine St., Cambridge, Md.	

23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 8, 1962	23c. NAME OF CEMETERY OR CREMATORIUM East New Market Cemetery	23d. LOCATION (City, town, or county) East New Market, Maryland	(State)
24. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DATE JAN 11 '62	25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

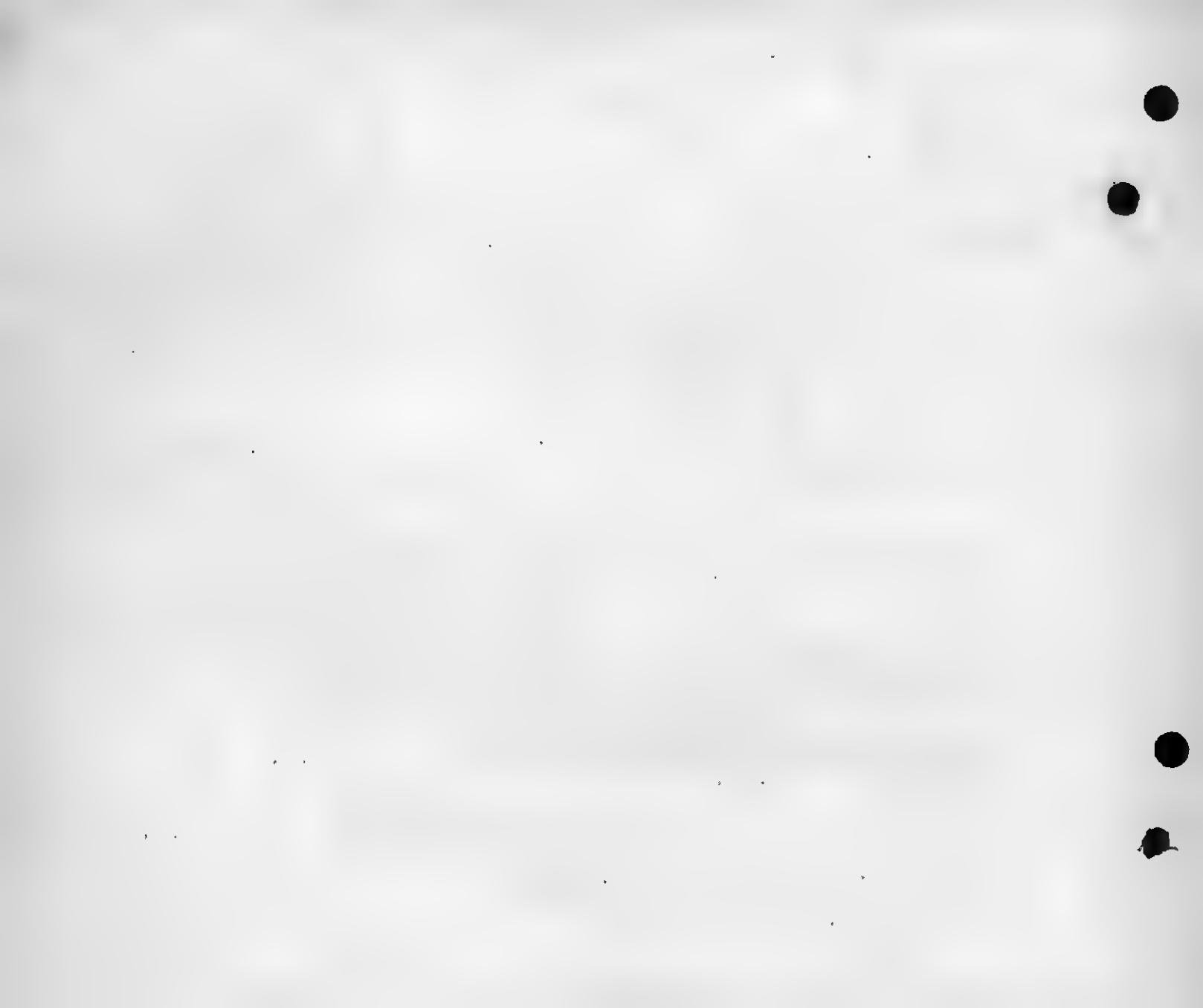


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00571 111570

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Williamsburg		d. STREET ADDRESS Near Williamsburg		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Rita		First	Middle	Last	4. DATE OF DEATH January	Month	Day	Year
S SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH December 11, 1961	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Mac Sims		14. MOTHER'S MAIDEN NAME Evelyn Jolley						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Evelyn Jolley, Hurlock, Md., RFD #1, Box 132A		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 47.5 X		Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 8 hrs.		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Upper respiratory infection				5 days		
DUE TO (c)		Smoke inhalation				10 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) Natural causes		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Smoke inhalation followed accidental fire within house-child then exposed to winter weather						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) home	20f. (City or town) -	(County) Dorchester	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 12.11. 1961 to 1.1. 1961, that (I) (we) last saw the deceased alive on 12.26.61 at 6:50 PM, and that death occurred at 1.1. 1961, from the causes and on the date stated above.								
22a. SIGNATURE <i>H. R. Trapnell</i>		M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 1.4.62		
22c. PHYSICIAN'S NAME (Type) H. R. Trapnell, M.D.		22d. ADDRESS Federalsburg, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 4, 1962	23c. NAME OF CEMETERY OR CREMATORIUM Federal Hill Cemetery		23d. LOCATION (City, town, or county) Federalsburg, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS		25a. REC'D BY REGISTRAR JAN 8 '62	25b. REGISTRAR'S SIGNATURE <i>C. J. J. Frampton</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 306 2-62 ans MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00572 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00571

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b <i>All life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Middle Street		d. STREET ADDRESS Middle Street	
3. NAME OF DECEASED (Type or print) Earl		4. DATE OF DEATH Last Month Day Year Jones January 24 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> March 31, 1905	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
10c. BIRTHPLACE (State or foreign country) <i>Md.</i>		11. AGE (In years last birthday) 50 yrs.	
13. FATHER'S NAME William Jones		14. MOTHER'S MAIDEN NAME Lillian Todd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <input type="checkbox"/> <i>No</i>		16. SOCIAL SECURITY NO. <i>217-05-8044</i>	
17. INFORMANT <i>J. Sard Jones</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>PENDING</i> Acute alcoholism	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Alfred R. M. Ryanov</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 136 Race St., Cambridge Md.	
EXAMINER'S NAME (Type) Alfred R. M. Ryanov, M. D.		DATE SIGNED 1/26/62	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/26/62</i>	
22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial		22d. LOCATION (City, town, or county) <i>Cambridge Md.</i>	
23. FUNERAL DIRECTOR <i>Keith J. Tillinghast, East New Market, Md.</i>		24a. REC'D BY REGISTRAR JAN 30 '62	
ADDRESS <i>Keith J. Tillinghast, East New Market, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred R. M. Ryanov</i>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

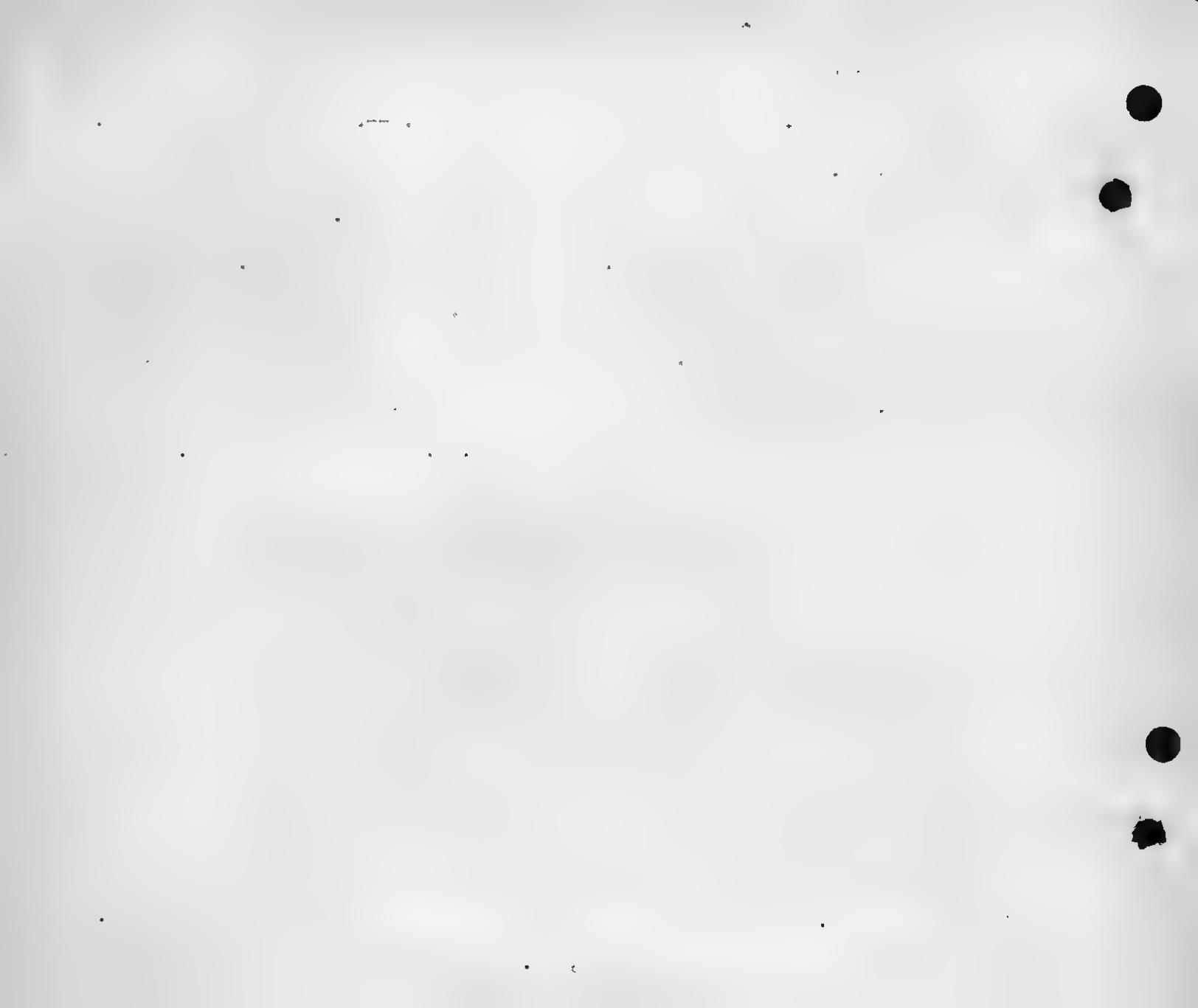
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00573 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

011572

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND c. LENGTH OF STAY IN lb 7 mo. 1 day		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Massey		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		d. STREET ADDRESS		d. STREET ADDRESS	
14 X				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence		Last Jones		4. DATE OF DEATH January 31 1962	
5. SEX Female		First M ddle		5. SEX Female	
6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-20-1881	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 80 yrs.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		10. IF UNDER 1 YEAR Months Days	
13. FATHER'S NAME Clarence S. Hurlock		14. MOTHER'S MAIDEN NAME Addie McGinnis		11. IF UNDER 24 HRS. Hours Min.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or peace of service)		16. SOCIAL SECURITY NO.		17. INFORMANT None	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		RECORDS - Eastern Shore State Hospital		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) + Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last		DUE TO (b) + (c) Complicated by aspiration of stomach contents		INTERVAL BETWEEN ONSET AND DEATH - 3 days - 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		RECORDS - Eastern Shore State Hospital		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) ALFRED R. MARYANOV		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/31/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 5, 1962		22c. NAME OF CEMETERY OR CREMATORIUM Cecilton Cemetery	
23. FUNERAL DIRECTOR Edward Galloway Millington, Md.		ADDRESS		24a. REC'D BY REGISTRAR Cecilton, Cecil Co., Md.	
VS AISME 5M 9 60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE FEB 2 '62	



FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-train permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00575

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00574

1. PLACE OF DEATH
a. COUNTY

Dorchester

MARYLAND

c. LENGTH OF STAY IN 1b

1 day

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Cambridge-Maryland Hospital

3. NAME OF
DECEASED
(Type or print)

Rosalie

Bassett

Meekins

5. SEX

Female

White

6. COLOR OR RACE

WIDOWED

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Divorced

9. DATE OF
DEATH

July 9, 1903

10. USAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Homemaker

13. FATHER'S NAME

John W. Bassett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

416.0
DUE TO
Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause first

(b)
DUE TO
Second & Third degree burns arms and legs.

(c)
Asphyxia

INTERVAL BETWEEN
ONSET AND DEATH

5 Min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Bed caught fire.

20c. TIME OF INJURY Month, Day, Year

1 PM 1/18/63

How
a.m.
p.m.

20d. INJURY OCCURRED While
at work at work Home

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

Cambridge

(County)

Dor. Md.

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country)

(State)

22e. REC'D BY REG. STRR

24b. REGISTRAR'S SIGNATURE

23. FUNERAL DIRECTOR

ADDRESS

Cambridge, Md.

DATE JAN 24 '62

Signature

1/20/62

Signature



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00576
001575

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Rural		c. LENGTH OF STAY IN 1b 1 month-3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna X				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS Market St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Lillian (Hackett)		First	Middle	Last	4. DATE OF DEATH January 31 1962	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH July 7, 1878	9. AGE (In years lost birthday) 83 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Rob-Kat-Kat Knitwear Factory		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Mona S. Alton Hackett		14. MOTHER'S MAIDEN NAME Charles Anna Shehe						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-09-3270		17. INFORMANT Records-Eastern Shore State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 15 min.		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Cerebral vascular accident, left, massive						
DUE TO (b)		Arteriosclerotic C.V.D.				? years		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Hypertension						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from December 23, 1961, to January 31, 1962, that <input type="checkbox"/> (we) last saw the deceased alive on January 31, 1962, and that death occurred at 10:25 A.M. from the causes and on the date stated above.								
22a. SIGNATURE See M. Dunn		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) George M. Dunn		22d. ADDRESS Eastern Shore State Hospital, Cambridge, Md.				22b. DATE SIGNED 1/31/62		
23a. BURIAL, CREMATION, REMOVAL. (Specify)		23b. DATE THEREOF January 31, 1962		23c. NAME OF CEMETERY OR CREATORY Market		23d. LOCATION (City, town, or county) East New Market, Md.		(State)
24. FUNERAL DIRECTOR'S SIGNATURE See M. Dunn		ADDRESS Market		25a. REC'D BY REGISTRAR FEB 5 '62		25b. REGISTRAR'S SIGNATURE John S. Dunn		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 3 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00577 00576

1. PLACE OF DEATH
 a. COUNTY Dorchester Co. MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge Md. c. LENGTH OF STAY IN 1b 3 Months

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenburn Nursing Home

3. NAME OF DECEASED
 First: Lena Middle: H. Last: Mills

4. SEX Female **6. COLOR OR RACE** White **7. MARRIED** NEVER MARRIED b. DATE OF BIRTH APR. 15, 1878

8. DIVORCED **10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) None **10b. KIND OF BUSINESS OR INDUSTRY** None **11. BIRTHPLACE** (County & State, or foreign country) Dorchester Co.

13. FATHER'S NAME Unknown **14. MOTHER'S MAIDEN NAME** Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No **16. SOCIAL SECURITY NO.** None **17. INFORMANT** Lake Mills **18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

Part I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) 491X DUE TO Bronchopneumonia
 Conditions, if any, which give rise to immediate cause (b) _____
 (c) _____

Part I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
 (b) Dementia

20a. ACCIDENT WAS UNDERLYING CAUSE **OP. CONTRIBUTING CAUSE** **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year **20d. INJURY OCCURRED** While at work Not While at work **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** (County) (State)

Hour e.m. p.m. 19

21. I certify that (I) (this hospital) attended the deceased from 2/10/1952 to 2/29/62, 1962, that (I) (we) last saw the deceased alive on 2/29/1962, and that death occurred at 12 A.M. from the causes and on the date stated above.

22a. SIGNATURE *W.H. Hanks* **22b. DATE SIGNED** 2/13/62

22c. PHYSICIAN'S NAME (Type) W.H. Hanks **22d. ADDRESS** 104 Locust St Cambridge Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial **23b. DATE THEREOF** Feb. 1, 1962 **23c. NAME OF CEMETERY OR CREMATORIUM** Greenlawn Cemetery **23d. LOCATION (City, town or county)** Cambridge, Maryland **23e. (State)**

24 FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service **ADDRESS** Cambridge, Md. **25a. REC'D BY REGISTRAR** 25b. REGISTRAR'S SIGNATURE
 DATE FEB 6 '62 *Le Compte S. Krasa*



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00578

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01824

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Funeral Director; Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural		c. LENGTH OF STAY IN b. Life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Near Shiloh		d. STREET ADDRESS Near Shiloh	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George		First	Middle
4. DATE OF DEATH January 31 1962		Last	
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH February 6, 1890		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
10c. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
12. FATHER'S NAME Andrew Neal		13. MOTHER'S MAIDEN NAME Sallie (maiden name unknown)	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		15. SOCIAL SECURITY NO. 215-26-5070	
16. INFORMANT H. Curtis Neal, Rhodesdale, Md., RFD		17. ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 42001 DUE TO Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Instant	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORIAL Feb. 5, 1962 Rhodesdale Cemetery	
22d. LOCATION (City, town, or country) Near Rhodesdale, Maryland		24a. REC'D BY REGISTRAR J. J. Frampton and Son, Federalsburg, Maryland DATE FEB 9 '62	
23. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		24b. REGISTRAR'S SIGNATURE James S. Kraus	



1
FOR STATE
HEALTH DEPT.

TO DEPUTED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Dorchester

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

rural Cambridge

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Eastern Shore State Hospital

3. NAME OF
DECEASED
(Type or print)

Leonard

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

Widower

Divorced

Middle

Earl

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

13. FATHER'S NAME

William Plummer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service

no

16. SOCIAL SECURITY NO.

17. INFORMANT

220-09-8478 Medical Records ESSH Cambridge, Md

Catherine L. SILTON

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

420-1
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.
(b)
(c)

Myocardial infarction

INTERVAL BETWEEN
ONSET AND DEATH
55 Min.

2
MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Chronic brain syndrome due to circulatory disturbance.

19. WAS AUTOPSY PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

John Mace Jr.

EXAMINER'S
NAME (Type)

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

1/28/62

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF
1/31/62

22c. NAME OF CEMETERY OR CREMATORIUM
Western

22d. LOCATION (City, town, or county)
Baltimore Md

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

1/28/62

24b. REGISTRAR'S SIGNATURE
John S. Kearns

Y.S. A15ME
5M 9.60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 3 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00580

011578

CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Dorchester Co.		a. STATE	b. COUNTY
b. CITY OR TOWN (If out-side corporate limits, write RURAL and give nearest town)		Maryland	
Cambridge, Md.		c. LENGTH OF STAY IN lb	
1 Day		X Bishop Head, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Cambridge Md. Hospital		Bishop Head, Md.	
3. NAME OF DECEASED (Type or print)		First	Middle
Iris		Bramble	Pritchett
5. SEX		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. COLOR OR RACE
Female		WIDOWED <input type="checkbox"/>	White
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John C. Bramble		Roxy Bramble	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give rank or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
No		Clarence Pritchett	
18. CAUSE OF DEATH (Enter only one cause of death for (e), (b), and (c).)		Bishop Head, Maryland	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		None	
(b)		Clarence Pritchett	
DUE TO Hypertension		Bishop Head, Maryland	
(c)		36 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Obesity			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
		(State)	
21. I certify that (I) (this hospital) attended the deceased from..... 1/26 1962 to..... 1/27 1962, that (I) (we) last saw the deceased alive on..... 1/27 1962, and that death occurred..... 1/27 1962, from the causes and on the date stated above.		22b. DATE SIGNED	
22c. SIGNATURE		1/29/62	
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS.	MED. DIRECTOR
W.H. Hanks.		<input checked="" type="checkbox"/>	<input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
Burial		Jan. 30, 1962 Dorchester Mem. Park	
24 FUNERAL DIRECTOR'S SIGNATURE		23d. LOCATION (City, town or county) (State)	
LeCompte Funeral Service		Cambridge, Maryland	
VR A15 (4) 15M 7'6"		25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
		DATE FEB 6 '62 Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be done by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00581

CERTIFICATE OF DEATH

001579

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY		a. STATE	
Dorchester Co.		Md.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Cambridge Md.		Dorchester Co.	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
2 Days		X Crocheron, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
Cambridge Md. Hospital		Crocheron, Md.	
First Middle		Last	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Martha Mabel		Pritchett Jan. 7, 1962	
5. SEX		5. COLOR OR RACE	
Female		White	
6. MARRIED		7. WIDOWED	
<input type="checkbox"/> NEVER MARRIED		<input checked="" type="checkbox"/> DIVORCED	
8. DOWED		<input type="checkbox"/> DIVORCED	
9. B. DATE OF BIRTH		10. AGE (In years last birthday)	
July 26, 1897		61 yrs.	
10a. JESAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None		None	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Crocheron, Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James Riley		Sarah Mills	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT		Address	
None		Riley W. Pritchett Lakesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> 260X Conditions, if any, which gave rise to immediate cause (b) <i>Arteriosclerosis</i> (c) <i>Diabetes Mellitus</i>		17 days	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART Ia)		19. WAS AUTOPSY PERFORMED?	
<i>Supraventricular tachycardia extremely slow</i>		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY		20d. INJURY OCCURRED	
Hour a.m.	Month, Day, Year	While at work	Not While at work
p.m.	19	<input type="checkbox"/>	<input type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from.....		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Jan. 7, 1962		20f. (City or town)	
saw the deceased alive on.....		(County)	
Jan. 7, 1962		(State)	
22a. SIGNATURE		22b. DATE SIGNED	
<i>W. H. Hanks</i>			
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
Dr. W. H. Hanks		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		Jan. 9, 1962	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)	
Bethany Churchyard		Crocheron, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
LeCompte Funeral Service		25b. REGISTRAR'S SIGNATURE	
ADDRESS		DATE JAN 12 '62	
Cambridge, Md.		Signature S. Krome	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retrodated by the hospital or attending physician.

FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retrodated by the hospital or attending physician.

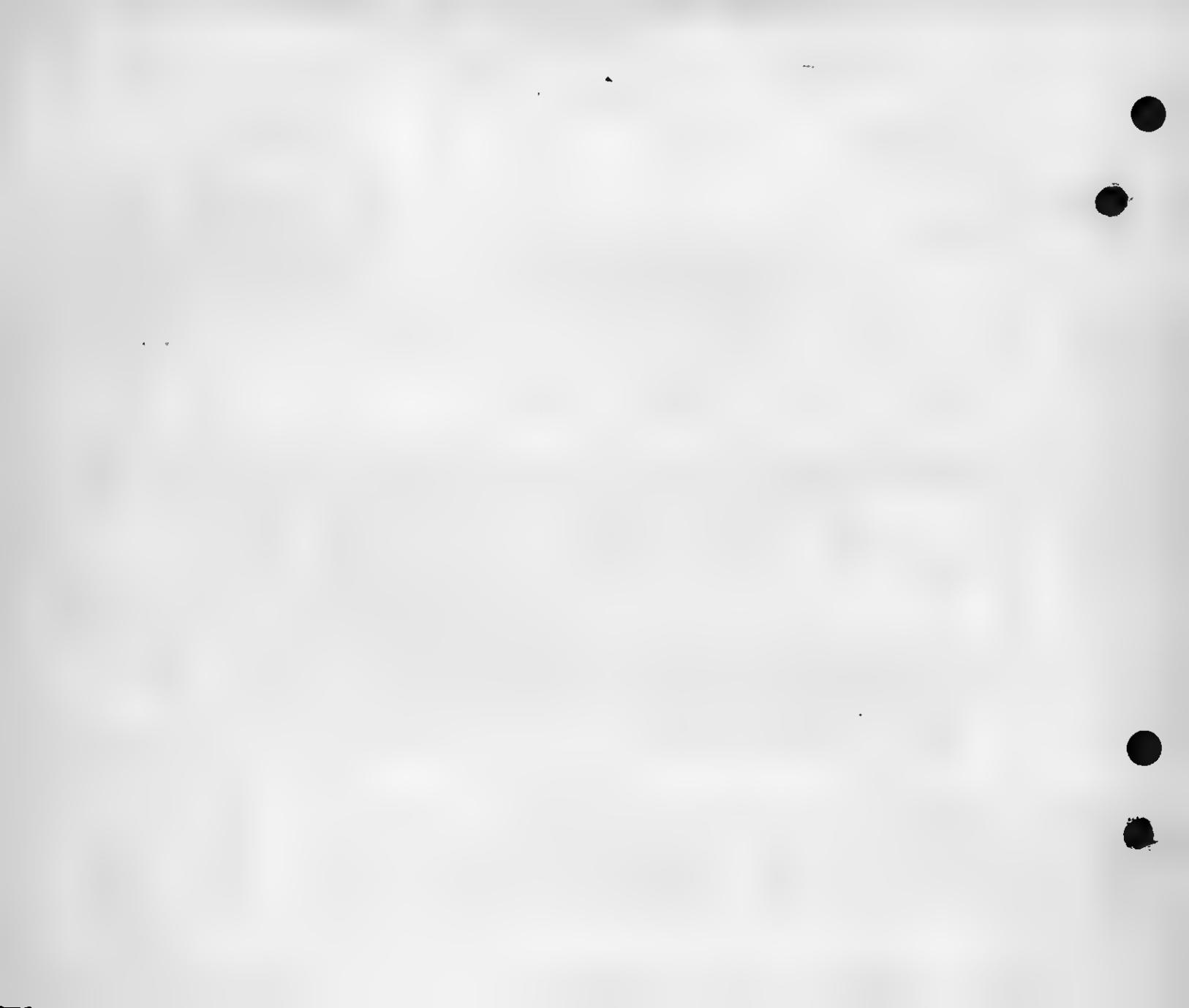
FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate is for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

Reg. Dist. No. 11115811

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hurlock, Maryland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Baby Girl		First	Middle	Lost	4. DATE OF DEATH January	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1962		9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Oak Dodson			14. MOTHER'S MAIDEN NAME Mildred Smith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Oak Dodson Hurlock, Maryland		Address	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Subarachnoid haemorrhage 24 hr Prematurity 5 day</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)</p> <p>DUE TO</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hurlock, Md.		(County) <u></u> (State) <u></u>
21. I certify that I attended the deceased from <u>Jan. 23, 1962</u> to <u>Jan. 28, 1962</u> , that I last saw the deceased alive on <u>Jan. 28, 1962</u> , and that death occurred at <u>9:21 AM</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Jason F. G. Yee</i>		ADDRESS (Street, city or town, state) <u>Hurlock, Md.</u> DATE SIGNED <u>1-28-62</u>						
PHYSICIAN'S NAME (Type) <i>Jason F. G. YEE, M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 29, 1962</u>		22b. DATE THEREOF <u>Jan 29, 1962</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Washington Cemetery</u>		22d. LOCATION (City, town, or county) <u>Hurlock, Md.</u> (State) <u></u>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Y. Clark Dodson</i>		ADDRESS <u>Hurlock, Md.</u>		24a. REC'D BY REGISTRAR <u>1 '62</u>		24b. REGISTRAR'S SIGNATURE <i>Carlyle S. Thrane</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 66581

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 15 hrs 30 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		d. STREET ADDRESS 209 Willis St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Spicer		Middle Spicer		4. DATE OF DEATH January 2 1962	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> EVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 - 2 - 62	9. AGE (In years from birth) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George James Spicer		14. MOTHER'S MAIDEN NAME Ruth Ann Long		Address Mrs. Ruth Spicer - 209 Willis St. Cambridge, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)							
16. SOCIAL SECURITY NO.							
17. INFORMANT							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (wgt-13oz)</u> DUE TO 16X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) _____ DUE TO (c) _____							
INTERVAL BETWEEN ONSET AND DEATH 25 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-2, 1962, to 1-2, 1962, that I last saw the deceased alive on 1-2, 1962, and that death occurred at 2:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D. DATE SIGNED 1-3-62							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation							
22b. DATE THEREOF 7-1-62		22c. NAME OF CEMETERY OR CREMATORIAL Cambridge Maryland Hospital		22d. LOCATION (City, town, or county) Cambridge, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frances Keeney-Ry</u> 2667315090				24a. REC'D BY REGISTRAR FEB 1 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
VS A15 (4) 15M 9/55 acting							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **P** may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

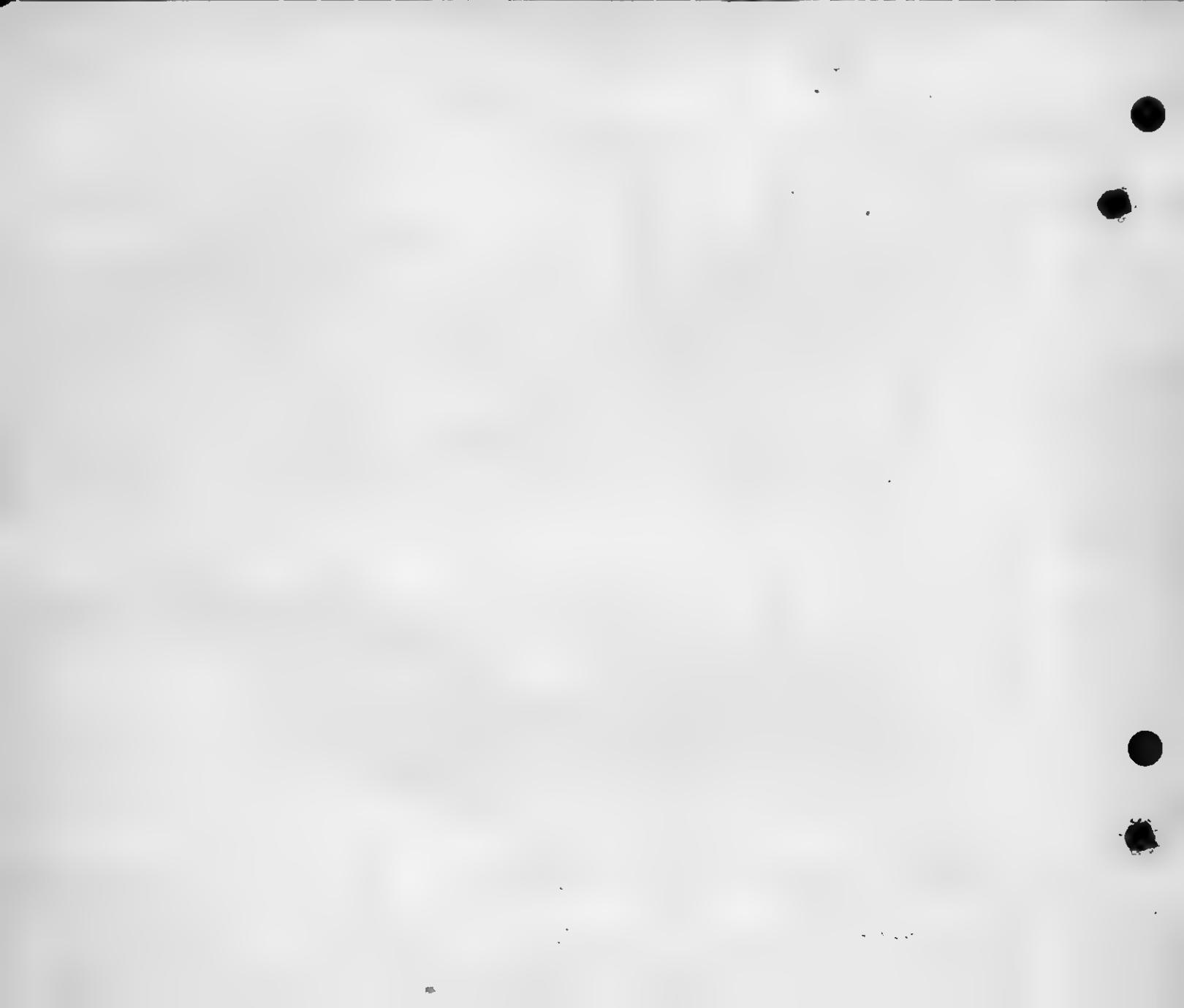
M

27

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. STATE Maryland	
Circleville		From 10/10/61		b. COUNTY Somerset	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Crisfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Eastern Shore State Hospital		Crisfield		Crisfield	
e. STREET ADDRESS		MARINERS ROAD		193 1/2	
First Middle		Last		DATE OF DEATH	
Edith Mae		Sterling		Month Day Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F.		W.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
Unknown		86 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Unknown		—		Unknown	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		Somerset	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(Yes, no, or unknown)		220-09-1743		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		22. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO		Cyr. Brain Synd. assoc. with Senile Brain Disease with Poyett	
{ (b)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
{ (c)		DUE TO		24. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour a.m. p.m. 19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		(City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/10/61 to 1/21/62 that (I) (we) last saw the deceased alive on 1/20/62, and that death occurred at 4:45 A.M. from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED	
Simon Vitkutis		M.D.		January 21, 1962	
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		23d. LOCATION (City, town or county)	
Simon Vitkutis		22d. ADDRESS		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)	
BURIAL JAN. 23, 1962		SUNNYRIDGE CEMETERY		CRISFIELD, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR	
BRAOCHAN + SONS, CRISFIELD, MD.		Crisfield		25b. REGISTRAR'S SIGNATURE	
ADDRESS		DATE JAN 25 '62		Cuthbert S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 111583

00585			
1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 61 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 Maryland Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
3. NAME OF DECEASED (Type or print) Ida		First Middle Richardson	4. DATE OF DEATH Lost Month January Day 24, 1962 Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Green's Island, Dor. C.	
13. FATHER'S NAME John Richardson		14. MOTHER'S MAIDEN NAME Georgeanna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Leroy Brown, 306 Maryland Ave., Camb., M.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 5 Min.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Coronary Occlusion	
DUE TO (b) Arteriosclerotic C-V Disease		10 yrs.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 1962, to Jan. 24, 1962, that I last saw the deceased alive on January 23, 1962, and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		ADDRESS (Street, city or town, state) M.D.	
22a. BURIAL/CREMATION, REMOVAL (Specify) Burial Jan. 26, 1962 Cambridge Cemetery			
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) Cambridge, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Renewell P. Thomas</i>		24a. REC'D BY REGISTRAR ADDRESS Cambridge, Md.	24b. REGISTRAR'S SIGNATURE DATE JAN 29 '62 <i>J. P. M. S. Davis</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death or by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be sure to sign and complete this certificate in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00586

CERTIFICATE OF DEATH

00584

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)	
Dorchester Co. MARYLAND		Cambridge, Md.		1 Week		a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		b. COUNTY Dorchester Co.	
Cambridge, Md.		Toddvile, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS					
Cambridge Md. Hospital							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day
Melissa		Francis	Todd		Jan. 19	19	62
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)		
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 7, 1896	65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?
Crab Picker		Seafood		Dorchester Co.			U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Asbury C. Meredith		Dorinda Todd		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			
No		212-16-7901		Mr. Todd		Toddvile, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Mesenteric thrombosis Intestinal obstruction Metastatic Carcinoma (cervix)					
17 IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		3 days					
DUE TO (c)		2 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		6 mos.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 7/11/1967 to 1/19/1962, that (I) (we) last saw the deceased alive on 1/19/1967, and that death occurred at 10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W.H. Hanks M.D.		22b. DATE SIGNED 1/23/62					
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 22, 1962	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park	23d. LOCATION (City, town or county) Cambridge, Md.	(State)		
24 FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE JAN 29 '62	25b. REGISTRAR'S SIGNATURE Charles S. Hanks		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00587

CERTIFICATE OF DEATH

00585

1. PLACE OF DEATH

a. COUNTY

Dorchester Co.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge, Md.

c. LENGTH OF STAY IN lb

1 Day

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Cambridge Md. Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle

Thelma

Parker

Tolley

4. SEX

6. COLOR OR RACE

7. MARRIED

8. DATE OF BIRTH

Female

White

WIDOWED

DIVORCED

Jan. 15, 1906

9. AGE (In years
last birthday)

55

yr.

10. IF UNDER 1 YEAR

Months

Deys

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Crab Picker

10b. KIND OF BUSINESS OR INDUSTRY

Seafood

11. BIRTHPLACE (County & State, or foreign country)

Dorchester Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Emory Parker

14. MOTHER'S MAIDEN NAME

Eva Flowers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Unknown

Mr. Vernon Tolley Honga, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

331X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

(c)

CEREBRAL HEMORRHAGE

INTERVAL BETWEEN
ONSET AND DEATH

2 DAYS

HYPERTENSION, ESSENTIAL

UNDET

PULMONARY DECOMPENSATION

3 DAYS

19. WAS AUTOPSY PERFORMED?

YES NO

DIABETES MELLITUS

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (His Hospital) attended the deceased from 12/18, 1961, to 1/13, 1962, that (I) (we) last saw the deceased alive on 1/13, 1962, and that death occurred at 9 AM, from the causes and on the date stated above.

22a. SIGNATURE

Alfred R. Maryanov

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

1/16/62

22c. PHYSICIAN'S
NAME (Type)

ALFRED R. MARYANOV

22d. ADDRESS

136 RACE ST, CAMBRIDGE, MD.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

Jan. 15, 1962

23c. NAME OF CEMETERY OR CREMATORIUM

Hoosier Church

23d. LOCATION (City, town or county) (State)

Fishing Creek,

Md.

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

LeCompte Funeral Service Cambridge, Md.

25a. REC'D BY REGISTRAR

JAN 18 '62

25b. REGISTRAR'S SIGNATURE

DATE

Arthur S. Krause

